# Self-Pay Patient Acknowledgement and Financial Authorization

A. **CONSENT FOR TREATMENT**: I consent to being treated as a patient of **Hammers and Riccio Imaging, PLLC *(H&RI)*** for the purpose of receiving ultrasound services, ultrasound guided treatments and/or diagnostic procedures. I have the right to consent or to refuse any proposed procedure or therapeutic treatment and that discussion of the risks, benefits and alternatives to each procedure or treatment is available to me. I understand that these images will be stored in a secure manner that will protect my privacy. Images that identify me will be released and/or used outside the institution only with *my written authorization* or that of my legal representative.

B. **AUTHORIZATION FOR PAYMENT/FINANCIAL AGREEMENT**: You will be asked to provide picture ID at every visit this is to ensure that the information we have on file is correct. If there is a discrepancy on your record it is your responsibility to inform us and provide us with the correct information.

I agree to pay H&RI for all services and supplies provided to me and for any other applicable charges. I understand that I am required to make payments for services the same day that they are provided to me. I understand that H&RI is providing a convenience discount for services on the basis that no insurance or personal billing will be done. I also understand that if I do not pay for services on the day performed, H&RI will bill me directly for the entire cost of the treatment and I will not be eligible for the self-pay discount.

Refusal to pay these fees can result in your inability to reschedule, cancellation of your future appointments, or ultimately sent to an outside collection agency.

We accept Cash (exact amount), credit or debit cards and personal checks ($25 fee will be charged for any returned checks for insufficient funds). If my account is not paid, I will pay all costs incurred as a result of H&RI collection efforts, including, without limitation, attorneys' fees and court costs. If my bill is not paid in full, H&RI reserve the right not to provide any future medical services to me.

C. **COMMUNICATIONS**: If I have provided a telephone number or email address as a contact, I hereby authorize H&RI, along with their respective employees, agents, and business associates, to contact me via phone, text message or email using any type of artificial or pre-recorded voice or autodialed technologies for any reason permitted by law, including, without limitation, automated notifications, and appointment reminders.

D. **RELEASE OF INFORMATION**: I understand that H&RI can release all necessary health information for purposes of treatment, payment, and healthcare operations. I authorize the release any information from my medical record, to other treating providers and if applicable to third-party payers, including but not limited to insurance companies, managed care organizations, Medicare, Medicaid, and other governmental payors. I understand that H&RI may release any and all necessary information with respect to my treatment when required to do so by law.

Hammers & Riccio Imaging, PLLC

I understand that refusal of consent to release of health information will not jeopardize my right to obtain present or future treatment, except where disclosure is necessary for the treatment. I understand that I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance on it. The authorization provided in this Section C expires one year from the date signature. I understand that if I refuse to authorize release of information and this results in a refusal by my insurance company or other responsible payor to pay H&RI for my treatment, I will be responsible for the entire unpaid portion of my bill.

☐ **Accepts** ☐ **Declines** **Initials**: ________

E. **ACKNOWLEDGE OF RECEIPT OF PRIVACY PRACTICES**: I hereby acknowledge that I received upon request a copy of the medical practice's notice of Privacy Practices. I further acknowledge that a copy of the current policy is posted in the reception area.

F. List of any person **(other than yourself and your physicians)** you give permission to speak with about your healthcare

| ______________________ | ______________________ | ______________________ |
|---|---|---|
| Name | Relationship | Contact |
| ______________________ | ______________________ | ______________________ |
| Name | Relationship | Contact |

By Signing Below, I acknowledge that I have read, understand and accept the policy.

►Patient Name: ______________________________ ► Date of birth: _______/ _______/ ________
MM DD YYYY

►Legal Guardian: ________________________________ ►Relationship: ____________________
If Applicable

►Signature: ______________________________ ►Today's date: _______/ _______/ ________
MM DD YYYY

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